M•Plan Benefits & Services

State of Indiana Plan II

Maximum Out-of-Pocket	**Member Cost**
Contract Year Maximum Out-of-Pocket per Covered Person	$2,000
Contract Year Maximum Out-of-Pocket per Family	$4,000

Copays & coinsurance for prescription or biopharmaceutical drugs & products do not count toward the satisfaction of the out-of-pocket maximum.

Physician Office Services

Primary care physician office visits	$20 copay
Visits to specialist upon referral	$20 copay

Services include: Periodic physician check-ups and exams; prenatal and postnatal maternity visits; well child care and routine pediatric visits; immunizations and injections; allergy tests and treatment; hearing exams; care of immediate medical need; mammogram, PSA and colorectal exams & testing

Physician Hospital Services

Physician services for surgery, visits and examinations	No charge

Inpatient Hospital Services

Semi-private room and board	$500 per admission

Services include: Private room if medically necessary, Operating, recovery rooms and other special units including intensive care
Maternity care, Hospital ancillary services including laboratory, x-ray, EKG and other diagnostic services
Other services including anesthesia, physical therapy and medications, Administration of blood and blood plasma
Non-experimental organ transplants when prior authorized

Outpatient Services

Outpatient surgery	$250 per admission
Outpatient services including laboratory, x-ray, EKG and other diagnostic services	No charge
Other outpatient services for MRI, CT, PET and SPECT	$50 copay
Emergency room services for life-threatening medical emergencies	$75 per visit *(waived if admitted to hospital)*
Immediate/Urgent Care Center visit	$35 per visit

Mental Health Services

Inpatient mental health services for evaluation	$500 per admission
Outpatient visits for psychotherapy, crisis intervention or psychiatric testing	$20 copay
Psychiatric Intensive Outpatient Program (Ambulatory Level Two Mental Health Programs)	$20 copay

Substance Abuse Services

Inpatient substance abuse services for diagnosis and detoxification	$500 per admission
Outpatient visits for evaluation or crisis intervention	$20 per visit

Other Services

Dialysis	$20 copay
Durable medical equipment	20% of covered charges
Emergency ambulance	$50 copay per transport
Family planning including infertility counseling, testing to diagnosis, surgical treatment & sterilizations	20% of covered charges
Home health care in lieu of hospitalization	$20 per day
Morbid Obesity Surgery	20% of covered services plus applicable inpatient or outpatient copay
Prosthetic devices and corrective appliances	20% of covered charges
Physical, occupational and speech therapy	$20 copay per visit
Temporomandibular Joint Dysfunction or Disease (TMJ) when medically necessary and prior authorized	Applicable office visit, inpatient or outpatient copay
Transplants	$2,000 copay up to a maximum benefit of $1,000,000

Prescription Drugs

Prescription drugs for up to 30-day supply. OTC Select, Generic and Select Prescription Drugs are available through the participating mail order pharmacy for two thirty (30) day supply copayments for a 90-day supply. Non-Select is available for three thirty (30) day supply copayments for a 90-day supply. To be covered, certain prescription drugs may require Prior Authorization.

OTC Select Drugs	$ 5 copay
Generic prescription drugs	$10 copay
Formulary Brand Name Drugs and Formulary Diabetic Supplies	$20 copay
Brand Name or Generic Non-Formulary drugs	40% of covered charges ($40 minimum, $100 Maximum)
Biopharmaceutical drugs/injectable drugs	20% of covered charges
Diaphragms, cervical caps	20% of covered charges

$1 Million Lifetime Maximum Benefit (excluding transplants) per Covered Person

All services must be provided, prior authorized, or referred by the member's participating primary care physician except in cases of life-threatening emergency.

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Exclusions

- Any service not provided, arranged for, prior authorized or approved by the member's primary care physician other than for life-threatening emergency
- Any service not medically necessary
- Services for which coverage is provided or is required to be provided by law in a public/government facility
- Personal comfort items or convenience items in and out of the hospital (e.g. television, telephone)
- Skilled nursing facility, custodial care, nursing care, nursing home care, rest cures, and domiciliary care regardless of location or setting and long-term psychiatric management in any institutional or home-based setting including respite care, group homes, halfway houses and residential facilities.
- Physical exams required by a third party (e.g. employment, insurance, licensing)
- Dental services except for accidental traumatic injuries to sound natural teeth if treatment occurs within 24 hours of the accidental injury
- Conventional of surgical orthodontics
- Conventional of surgical orthognathics, unless the malocclusion is causing a persistent trauma to the gums or palate not correctable by orthodontia
- Cosmetic surgery
- Invitro fertilizations, artificial insemination and embryo transport services, GIFT and ZIFT
- Transsexual surgery; reversal of sterilization
- Marriage or sex counseling
- The evaluation or treatment of learning disabilities
- Infertility drugs
- Experimental psychiatric procedures, pharmacological regimen and associated health care services and/or those procedures that are not consistent with accepted standard medical practice or services requiring prior approval by any governmental authority prior to use where such approval has not been granted or services not approved for coverage by Medicare
- Vision care; Eye exams for contact lenses or their fitting; eyeglasses
- Hearing aids
- Chiropractic services
- Podiatry services, unless medically necessary
- Routine foot care
- Over-the-counter (OTC) drugs and supplies except those indicated as OTC Select
- Non-sedating antihistamines or low-sedating antihistamines
- Experimental health care services and drugs
- Skilled nursing facility services
- Prescription drugs for the treatment of sexual dysfunction
- Surgically implanted contraceptives
- Medications dispensed in a physician's office
- Services or supplies for the treatment of obesity unless medically necessary for life-threatening condition
- Allergy serum and allergy injections

Limitations

If circumstances arise beyond the control of the Plan (e.g. major disasters, epidemics); services will be rendered only as practicable within the limitations of available facilities and personnel.

If a member refuses recommended treatment for a medical condition when the primary care or referral physician and the Plan believe no acceptable alternative exists, further coverage related to that condition will be denied.

Members must use the Plan's participating providers. These providers are subject to change from time to time, and the Plan does not guarantee the length of service for any of its participating providers.

Copays

Copays are paid at the time of your office visit or when other services are received.

If you have any questions call or write:
M•PLAN CUSTOMER SOLUTIONS CENTER
(317) 571-5320 or 1-800-81-MPlan (800-816-7526)
8802 N. Meridian Street, Suite 100
Indianapolis, Indiana 46260

This brochure describes the essential features of the benefit plan and is not intended to be a full description of benefits.
The complete program is described in your employers' Group Service Agreement. Your Certificate of Coverage is a complete description of your benefits.